ICF/DD Quality Assurance Fee Quarterly Payment

California Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048 P.O. Box 997413
Sacramento, CA 95899-7413

Number (NPI):
Provider Number:
Due Date: 12/31/2007
Total Remitted: $_____

Provider Name	Provider No.	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
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Intermediate Care Facility/Developmentally Disabled (ICF/DD) Quality Assurance Fee Claim and Certification Form Quarter Period July – September 2007 (State Fiscal Year 07/08)

Completion of this form is mandatory.

1. Name of Facility	2. Parent Company, If Applicable	
3. Medi-Cal Provider No.	4. Facility Telephone Number	
5. Facility Street Address	6. City and State	7. Zip Code
8. Mailing Address (if different)	9. City and State	10. Zip Code

Calculation of the Quality Assurance Fee:

1. Gross receipts for the quarter (July – September 2007) received from:

   a. Medi-Cal fee-for-service (including share of costs) $_____

   b. Medi-Cal Managed Care health plans (e.g., Cal-Optima, Partnership Healthplan, etc.) $_____

   c. Other non-Medi-Cal (e.g., private pay) $_____

2. Total gross receipts for the quarter (sum of lines a, b and c) $_____

3. ICF/DD Quality Assurance Fee (No. 2 multiplied by 6% [.06]). Please remit this amount along with this form by December 31, 2007 to the address above: $_____

I am an administrator, officer or other individual duly authorized and designated to make this certification on behalf of the above named facility.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, correct and complete.

_____ _____
Original Signature Date Print name & title of person signing declaration

(DHCS 9085)